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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **HEIDI ROSE SLOAN** **P.O. Box 741** **La Canada, CA 91012** **Registered Nurse License No. 654465** Respondent.	Case No. 2010-126 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about March 14, 2005, the Board issued Registered Nurse License Number 654465 to Heidi Rose Sloan ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2010, unless renewed.

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STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

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8. Regulation 1443 states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AT ISSUE

10. "Lorazepam" is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(16).

11. "Dilaudid", a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

12. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

13. "Percocet", a brand of oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N).

FIRST CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

14. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that on or about October 31, 2006, and December 12, 2006, while employed by HRN Services, Inc., a nurse registry service, and assigned to work and on duty as a registered nurse at St. Jude Medical Center, Fullerton, California, Respondent falsified or made grossly

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incorrect, grossly inconsistent, or unintelligible entries in the medical center's records pertaining to the controlled substances lorazepam, Dilaudid, morphine, and Percocet, as follows:

Patient A:

a. On October 31, 2006, at 1027 hours, Respondent withdrew lorazepam 2 mg from the Pyxis medication dispensing system (hereinafter "Pyxis") for the patient and documented in the Pyxis that she wasted 1 mg of the medication as witnessed by another nurse when, in fact, the physician's order was not issued for the lorazepam until *1115* hours (the physician's order called for the administration of 1 mg of the medication every 4 hours as needed). Further, Respondent failed to chart the administration or wastage of the remaining 1 mg of lorazepam on the patient's medication administration record ("MAR") and otherwise account for the disposition of the 1 mg of lorazepam.

Patient B:

b. On October 31, 2006, at 1041 hours, Respondent withdrew lorazepam 2 mg from the Pyxis for the patient and documented in the Pyxis that she wasted 1.5 mg of the medication as witnessed by another nurse, but failed to chart the administration or wastage of the remaining .5 mg of lorazepam on the patient's MAR and/or otherwise account for the disposition of the .5 mg of lorazepam.

Patient C:

c. On December 12, 2006, at 1217 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis for the patient and documented in the Pyxis that she wasted 1.75 mg of the medication as witnessed by another nurse, but failed to chart the administration or wastage of the remaining .25 mg of Dilaudid on the patient's MAR and/or otherwise account for the disposition of the .25 mg of Dilaudid.

Patient D:

d. On December 12, 2006, at 0921 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis for the patient and documented in the Pyxis that she wasted 1 mg of the medication as witnessed by another nurse, but failed to chart the administration or wastage of the remaining

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1 mg of Dilaudid on the patient's MAR and/or otherwise account for the disposition of the 1 mg of Dilaudid.

e. On December 12, 2006, at 1134 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis for the patient and documented in the Pyxis that she wasted 1 mg of the medication as witnessed by another nurse, but failed to chart the administration or wastage of the remaining 1 mg of Dilaudid on the patient's MAR and/or otherwise account for the disposition of the 1 mg of Dilaudid.

Patient E:

f. On December 12, 2006, at 1418 hours, Respondent withdrew morphine 2 mg from the Pyxis for the patient, documented in the Pyxis that she wasted 1 mg of the medication as witnessed by another nurse, and charted on the patient's MAR that she administered 1 mg morphine to the patient at 1410 hours, but failed to document on the MAR or the nurses' notes the pain scale or the level of the patient's pain.

Patient F:

g. On December 12, 2006, at 1729 hours, Respondent withdrew 1 tablet of Percocet from the Pyxis for the patient, charted on the patient's MAR that she administered the Percocet to the patient at 1730 hours, but failed to document on the MAR or the nurses' notes the pain scale or the level of the patient's pain.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

15. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about October 31, 2006, and December 12, 2006, while employed by HRN Services, Inc., a nurse registry service, and assigned to work and on duty as a registered nurse at St. Jude Medical Center, Fullerton, California, Respondent was guilty of gross negligence within the meaning of Regulation 1442, as set forth in paragraph 14 subparagraphs (a) through (g), inclusive, above.

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THIRD CAUSE FOR DISCIPLINE

(Incompetence)

16. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about October 31, 2006, and December 12, 2006, while employed by HRN Services, Inc., a nurse registry service, and assigned to work and on duty as a registered nurse at St. Jude Medical Center, Fullerton, California, Respondent was guilty of incompetence within the meaning of Regulation 1443, as set forth in paragraph 14 subparagraphs (a) through (g), inclusive, above.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

17. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that on or about December 15, 2006, while employed by HRN Services, Inc., a nurse registry service (hereinafter "HRN"), and assigned to work and on duty as a registered nurse at St. Jude Medical Center ("St. Jude"), Fullerton, California, Respondent committed acts constituting unprofessional conduct, as follows: On the date indicated above, Respondent reported to work at St. Jude with a disheveled appearance. Later during Respondent's shift, the clinical director observed that Respondent's eyes were blood shot and that Respondent was smelling of smoke and had been vomiting in a trash can. It was also reported that Respondent was unable to complete her charting. Later that same day, the Director of Patient Care Services at HRN ("Director") received a complaint from a representative of St. Jude regarding Respondent's appearance and behavior while on duty. The Director requested that Respondent complete a drug test, but Respondent refused.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 654465, issued to Heidi Rose Sloan;

2. Ordering Heidi Rose Sloan to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 8/28/09

Louise R. Bailey

LOUISE R. BAILEY, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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